MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Cape Gir-

Township: ~~Hubble~~

or Village: Whitewater

or City: (NO. ____ St.: ____ Ward)

Registration District No. 130. File No. 30874

Primary Registration District No. 4073. Registered No. 20.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Edward Lloyd Becking

PERSONAL AND STATISTICAL PARTICULARS

SEX: Boy

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: Sept. (Month) 12 (Day), 1911 (Year)

AGE: ____ yrs. ____ mos. 7 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Whitewater Mo

PARENTS

NAME OF FATHER: Joseph G. Becking

BIRTHPLACE OF FATHER (City or town, State or foreign country): Rodgeway Ill.

MAIDEN NAME OF MOTHER: Columbia B. Cook

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Bloomfield, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph G Becking

(ADDRESS) Whitewater Mo

Filed Sept 20 1911. A. M. Murphy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. (Month) 20 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 19, 1911, to Sept 20, 1911, that I last saw him alive on Sept. 20, 1911, and that death occurred, on the date stated above, at 12 P.m.

The CAUSE OF DEATH* was as follows:

Dysentery

13 C 14

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. M. Murphy M. D.

Sept. 20, 1911 (Address) Whitewater Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Stoglewell Cty

DATE OF BURIAL: Sept 21, 1911

UNDERTAKER: Whitewater Mo. Per J. M. Slagle Co.

ADDRESS: Whitewater Mo

MISSOURI STATE BOARD OF HE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

[If death occ
hospital or i
give its NAM
of street and n

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____,
(Month) (Day)

I HEREBY CERTIFY, that I attended deceas
_____, 191____, to _____,
that I last saw h_____ alive on _____,
and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos.

(Signed) _____
_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Cau
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS
RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS

Revised United States Standard Certificate of Death

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary
important) affection need not be stated unless im-